DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE

IN RE: GREGORY VILLABONA, M.D.	)	**Case No.: 10-143-13**
	)	**10-97-17**
LICENSE NO.: C1-0004007	)	
	)	

ORDER ACCEPTING COMPLAINT AND GRANTING EMERGENCY TEMPORARY SUSPENSION

AND NOW, this 19th day of March, 2018,

WHEREAS, the Delaware Department of Justice through the prosecuting Deputy Attorney General has filed with the Board of Medical Licensure and Discipline a written Complaint and Motion for Temporary Suspension; and,

WHEREAS, Dr. Villabona is a licensed medical doctor in the state of Delaware with an active license issued in 1993; and

WHEREAS, said Complaint and Motion allege, among other things, that Dr. Villabona's medical license has been disciplined in 2003, 2007, and in 2008. As part of these disciplinary orders, Dr. Villabona was required to notify patients of his probationary status and the Board's restriction of his license in that he was not permitted to treat any female patient, or any patient under the age of 18. The Complaint and Motion allege that in connection with the current investigation, it has been discovered that Dr. Villabona is not complying with the notice requirement of his prior orders. The Complaint and Motion further allege that Dr. Villabona prescribed controlled substances for chronic pain for one patient for the past 13 years with only "few records prior to 2016 and no progress notes at all prior to 2016." After Dr. Villabona was informed by another physician that his patient's goals seemed to be directed at steering therapy toward receiving an oxycodone or long acting oxycodone prescription, Dr. Villabona continued to write for controlled substances for this patient. The Complaint and Motion allege that Dr.

Villabona treated a second patient for six years by prescribing controlled substances for chronic pain, and after being notified by law enforcement that his patient was obtaining multiple controlled substance prescriptions from multiple providers, Dr. Villabona continued to write controlled substance prescriptions for this patient. Dr. Villabona then received a notice from Criminal Drug Court, asking Dr. Villabona to switch this patient to non-addictive medications. Dr. Villabona ignored this notification as well, and continued to write prescriptions for controlled substances for this patient. The Complaint and Motion allege that Dr. Villabona provided a third patient with prescriptions for controlled substances when he knew that patient was receiving similar controlled substance prescriptions from other providers, without contacting the other providers Dr. Villabona knew were writing prescriptions for this patient. Dr. Villabona also prescribed controlled substances to this patient in response to a report of suicidal ideation, and after being informed that the patient was taking illegal street drugs. The Complaint and Motion allege Dr. Villabona prescribed controlled substances for at least four other patients with little to none of the Board's required documentation in any patient file. The Complaint and Motion further allege that Dr. Villabona handed another patient a handgun and switchblade to hold after several law enforcement officers arrived at Dr. Villabona's office. Finally, the Complaint and Motion allege that Dr. Villabona's office contained numerous prescription bottles, many expired, filled in the names of multiple patients, and alleges that Dr. Villabona would provide patients with medications from these bottles. Dr. Villabona also was found in possession of two handguns that are not registered to him, and is alleged to have bartered with patients providing them treatment in exchange for handguns, yard work, interior maintenance, and remodeling.

WHEREAS, the allegations if substantiated at a formal hearing constitute unprofessional

conduct under numerous provisions of the Medical Practice Act, including but not limited to, 24 *Del. C.* § 1731(b)(1), (2), (3), (6), (11), and (17) and Board Regulations 8.1.2, 8.1.12, 8.1.13, and 8.1.16; and

WHEREAS, Dr. Villabona's legal counsel was given at least 24 hours' written notice so that he or his counsel could file a written response in opposition to entry of an Order of Temporary Suspension together with a copy of the Complaint in compliance with 24 *Del. C.* § 1738(a); and

WHEREAS, Dr. Villabona's counsel responded by letter dated March 16, 2018 and indicates that the State's Amended complaint adds two new allegations regarding two additional patients whose care dates back to 2004 and 2006 and the remaining allegations have been previously denied by Dr. Villabona. Dr. Villabona admits to collecting medications back from patients and is working "with the FDA" on the proper disposal of these medications. Dr. Villabona's counsel asserts that nothing in the complaint alleges any action that rises to the level of presenting a clear and immediate danger to the public health, safety, or welfare and states that the Attorney General's office is being disingenuous to seek to suspend Dr. Villabona's license at this time.; and

WHEREAS, after reviewing the allegations in the State's Complaint *in toto,* said Complaint highlights the serious nature of Dr. Villabona's offenses. Further, the undersigned have an obligation to ensure the public health is protected. After due consideration of the Complaint and the Motion as well as the Response received, the Secretary of State or his designee with the concurrence of the Board President or his designee have therefore determined that the available information is sufficient to support the entry of an Order temporarily suspending Respondent's license to practice medicine in the State of Delaware in that there is a

reasonable belief that Respondent's continued practice presents a clear and immediate danger to the public health;

IT IS SO ORDERED this 19 day of March, 2018:

1. That the Motion for Emergency Suspension of Gregory Villabona's license to practice medicine (License No.: C1-0004007) is granted;

2. That Dr. Gregory Villabona shall be served with a copy of this Order as provided in 24 *Del. C.* § 1738(a) and notice shall be provided to all other agencies listed therein;

3. That Complaint numbers 10-143-13 and 10-97-17 are accepted by the Board as the Formal Complaint and shall be assigned to a hearing officer to be scheduled in accordance with 24 *Del. C.* § 1738 and 29 *Del. C.* § 8735(v)(1)d to hear evidence related to the Formal Complaint; and

4. That pursuant to 24 *Del. C.* § 1738, Dr. Villabona may request an expedited hearing provided that the Board receives the request within 5 calendar days of the date Dr. Villabona is notified of this Order.

George A. Dahr, M.D., President
Board of Medical Licensure & Discipline

The Honorable Jeffrey W. Bullock
Secretary of State, State of Delaware

BEFORE THE DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE

IN RE: GREGORY VILLABONA, M.D.	)	
	)	**Case Nos.: 10-143-13**
LICENSE NO.: C1-0004007	)	**10-97-17**

AMENDED COMPLAINT AND MOTION FOR TEMPORARY SUSPENSION

1. Gregory Villabona, M.D. ("Respondent") is a licensed physician in the State of Delaware. Respondent's license, number C1-0004007, was issued in 1992 and is active.

2. Respondent's Delaware controlled substances registration or CSR, number MD2327, was issued in 1993 and is active.

3. Respondent's primary specialty is psychiatry. He is a solo practitioner with a practice in Dover, Delaware.

Discipline History

4. On September 22, 2003, in Case No. 10-61-02, the Delaware Board of Medical Practice, now the Delaware Board of Medical Licensure and Discipline ("Board"), found that Respondent engaged in dishonorable and unprofessional conduct in violation of the *Medical Practice Act*. The violations arose out of his September 30, 2002 guilty plea in the Circuit Court for Queen Anne's County, Maryland to a third-degree sex offense on a female minor and a fourth-degree sex offense on a female minor.

5. The Board put Respondent's license on probation to run concurrent with his Maryland criminal probation. The disciplinary Order prohibited Respondent from seeing minor patients without the presence of an adult family member, and it required Respondent to disclose his admitted sexual crimes to all present and future patients in writing. The prosecuting Deputy Attorney General had to approve the written notice. Respondent was not permitted to treat a patient unless the patient executed a notice form to be kept in the patient's file.

6. On November 1, 2005, the Board terminated Respondent's probation, but ordered that he continue to provide a form notice to his present and future patients regarding his sexual crimes. The Board further ordered that Respondent could not treat minor patients without having an adult present.

7. On June 6, 2007, the Board entered an Order in Case No. 10-61-02 imposing disciplinary sanctions against Respondent for violating its prior Orders. Respondent violated the Board's requirement that he have adult supervision when treating a minor. The Board placed Respondent's license on probation for three years and continued the prior notice requirement. The Order also required Respondent to notify patients of his probation status and prohibited Respondent from treating any patients under the age of 18.

8. On June 3, 2008, the Board entered an Order accepting the Consent Agreement of the parties in Case No. 10-35-06. Respondent admitted to having consensual sexual relations with a 22-year-old female patient in violation of the *Medical Practice Act.* His discipline included a permanent restriction on his medical practice permitting treatment of only male patients over the age of 18. The Order continued the probation on his medical license, previously scheduled to terminate in June 2010, until June 2015.

9. In connection with investigations of new complaint against Respondent in Case No. 10-143-13 and 10-97-17, the Division of Professional Regulation ("DPR") subpoenaed certain patient files from Respondent. For many of the patients, Respondent's treatment dated back to the time of his first disciplinary Orders, or before.

10. For some patients, Respondent utilized an approved notice form notifying the patient of his Board discipline and of his admitted sex crimes. Many of Respondent's subpoenaed patient files, however, do not contain the required notice form at all in violation of the Board's

conditions placed upon him in its September 22, 2003, November 1, 2005 and June 6, 2007 Orders.

11. For at least one patient, Respondent also utilized a second written notice, not approved by the Board or a Deputy Attorney General, stating that he was falsely accused of the criminal charges and incorrectly stating that the Board found no evidence of his guilt. The statement to his patient that he was falsely accused is in direct contradiction of his plea of guilty in Maryland, where he admitted to guilt before the Maryland court.

12. Respondent's use of this second unapproved form is a violation of the Board's conditions placed upon him in its September 22, 2003, November 1, 2005, and June 6, 2007 Orders.

Patients

Patient U

13. Respondent began treating Patient U in 2004 and treatment continued through 2017. Respondent's treatment of Patient U included prescribing controlled substances for chronic pain for adhesive arachnoiditis and for mental health, including depressive disorder and post-traumatic stress syndrome.

14. Respondent's records for Patient U contain few records prior to 2016 and no progress notes at all prior to 2016. There are no documented diagnoses prior to the prescribing of controlled substances to Patient U.

15. Prescription Monitoring Program ("PMP") records document that Respondent was prescribing controlled substances to Patient U as far back as at least 2011.[1] The prescribing includes methadone 5 mg and 10 mg (Schedule II Controlled Substance or "CS"); hydrocodone-acetaminophen 10-325 (Schedule II); lorazepam 1 mg and 2 mg (Schedule IV); testosterone, CYP

[1] The PMP database began in 2011.

200 mg (Schedule III); dextroamphetamine, 5mg, 10 mg and 20 mg (Schedule II); oxycodone, 15 and 20 mg (Schedule II); carisoprodol, 350 mg (Schedule IV); and methylphenidate, 10 mg (Schedule II).

16. In June of 2015, Respondent received a progress note from Dr. Howard Arian, a pain management practitioner, following an appointment of Patient U with Dr. Arian. Dr. Arian completed a full physical exam and found no evidence of "adhesive arachnoiditis." Dr. Arian's record documents that the patient's "goal during his interview and exam seemed to be directed at steering therapy toward receiving an oxycodone or long acting oxycodone prescriptions." Dr. Arian recommended a multidisciplinary approach at a university pain center and declined to take on the care of Patient U.

17. Dr. Senad Cemerlic, a pain management practitioner, prescribed controlled drugs to Patient U over the next year, and then Respondent took over the pain management of Patient U in February of 2016. Respondent did not document a response to the red flags raised by Dr. Arian, and did not document a discussion of Dr. Arian's concerns with Patient U. Respondent did not consult with Dr. Cemerlic or obtain his records.

Patient M

18. Respondent began treating Patient M in at least 2009, and treatment continued through at least 2015. Respondent's treatment of Patient M included prescribing controlled substances for chronic pain and mental health, including adjustment disorder with anxiety and depression.

19. Prescription records in Patient M's file document that Respondent prescribed oxycodone-acetaminophen (Schedule II), methylphenidate 20 mg (Schedule II), oxycodone 15 mg (Schedule II), Soma (Schedule IV), and alprazolam 2 mg (Schedule IV) to Patient M between

April 2009 and August 2011, when the prescriptions records end.

20. PMP records beginning in 2011 document that Respondent prescribed oxycodone 15 mg (Schedule II), alprazolam 2 mg (Schedule IV), methylphenidate 20 mg (Schedule II), and hydrocodone-acetaminophen 10-325 (Schedule II) to Patient M between September 2011 and August 2015.

21. In 2012, law enforcement and another physician notified Respondent that Patient M was receiving narcotics from multiple prescribers. An employee of Respondent documented a discussion with Patient M regarding the report and that Patient M stated he was not receiving narcotics from multiple providers and had been confused with his father of the same name. Respondent accepted Patient M's explanation without contacting law enforcement or the other physician. Respondent continued to prescribe controlled drugs, including oxycodone, to Patient M despite this notice.

22. On July 16, 2013, the Drug Court Diversion case manager sent correspondence to Respondent to notify him of Patient M's participation in the Drug Court Diversion Program. The letter was sent on behalf of the Delaware Superior Court and Kent Sussex Counseling Services and requested that Respondent switch Patient M from his prescribed addictive medications to non-addictive medications.

23. The letter states: "[h]istorically, when treating addicted persons while they are being prescribed addictive mediations, it has been next to impossible to move them into abstinence. The addictive medication keeps the craving cycle going and does not allow their disease to be arrested."

24. Despite this notification, Respondent's knowledge of Patient M's participation in a court ordered substance abuse treatment program, and prior notice of Patient M's illegal doctor

shopping, Respondent continued to prescribe controlled addictive drugs to Patient M, specifically oxycodone 15 mg (90 per month) (Schedule II) and methylphenidate 20 mg (Schedule II) and hydrocodone-acetaminophen 10-325 (Schedule II).

25. Respondent did not document any discussion of addiction issues with Patient M and he did not coordinate care with Kent Sussex Counseling Services.

26. In 2015, Patient M's parent confronted Respondent about the controlled drugs Respondent prescribed to her son and demanded Respondent stop prescribing because of Patient M's addiction. The parent threatened to report Respondent. There is no documentation of this conversation or any response to the parent's concerns in the patient record.

27. Respondent's treatment records for Patient M end abruptly in July 2015 and PMP prescribing records end in August 2015.

28. Patient M died from a heroin overdose in January of 2016.

Patient T

29. Respondent began treating Patient T in at least 2006. Until 2014, Respondent primarily treated Patient T's psychiatric issues while Patient T received chronic pain treatment from other providers.

30. In March of 2014, Patient T was treating with Dr. Patrick Callahan for his pain. On March 24, 2014, Dr. Callahan prescribed a 30-day supply of morphine sulfate extended release, 60 mg (Schedule II), three times per day.

31. On April 22, 2014, Patient T reported to Respondent that the pain medications provided by Dr. Callahan were insufficient. Respondent began prescribing controlled drugs to Patient T, purportedly for his pain, without consulting with Dr. Callahan or obtaining his records and without a diagnosis. Respondent prescribed oxymorphone, extended release 30 mg (Schedule

II).

32. Respondent prescribed the oxymorphone in addition to the existing and ongoing prescriptions of Clonazepam 2 mg (Schedule IV) and dextroamphetamine, 30 mg (Schedule II).

33. On September 30, 2014, Respondent added carisoprodol 350 mg (Schedule IV) to Patient T's drug regime, without explanation or justification in the record other than the patient's report that the oxymorphone was "less than adequate" to control his pain.

34. Respondent continued to prescribe controlled drugs to Patient T for his pain until February 2015. In February 2015, Patient T began seeing Dr. Uday Uthaman for his chronic pain.

35. In April of 2016, Patient T reported to Respondent that he left the care of Dr. Uthaman because he was angry when the doctor decreased his pain medications again. At the request of Patient T, Respondent again began prescribing controlled drugs to Patient T purportedly to treat Patient T's chronic pain. Respondent prescribed methadone 10 mg (Schedule II) to Patient T without consulting with Dr. Uthaman or obtaining his records.

36. In May of 2016, Respondent prescribed hydrocodone-acetaminophen 325 mg/10 mg (Schedule II) to Patient T without documenting any justification in the record and after the patient reported he had been out of narcotics for two weeks and felt he was going through withdrawal. In May 2016, Respondent also prescribed methadone 10 mg (Schedule II) to Patient T.

37. On June 27, 2016, patient T reported to Respondent that he saw a pain management specialist and was approved for treatment but was unable to produce a sufficient urine sample.

38. On July 28, 2016, a family member of Patient T called Respondent to express concern over Patient T's mental status and intentions of suicide. Respondent saw Patient T on an urgent basis on July 29, 2016. On that same date, Respondent prescribed controlled drugs to

Patient T, specifically Dilaudid, 4 mg (Schedule II) without justification in the record for the drug. Respondent did not adequately address the mental health issues raised by the family member.

39. On January 24, 2017, Patient T reported using LSD to Respondent. On that same date, Respondent prescribed controlled drugs to Patient T after receiving this report of illegal drug use. Respondent did not counsel Patient T on the use of illegal drugs. Respondent prescribed dextroamphetmine 30 mg (Schedule II), clonazepam 2 mg (Schedule IV), and zolpidem 10 mg (Schedule IV) along with non-controlled medications, including Lexapro, 20 mg.

Patient D

40. Respondent began prescribing to Patient D in at least May 2015 and prescribing continued through at least July 2015. PMP records document that Respondent prescribed oxycodone 30 mg (Schedule II) on at least 13 dates between May and July of 2015, typically a seven-day supply of 28 pills.

41. Respondent failed to maintain any records on Patient D and failed to establish a physician/patient relationship with Patient D before prescribing addictive controlled substances to him.

Patient P

42. Respondent began treating Patient P in at least 2009, and treatment continued through at least 2016. Respondent's treatment of Patient P included prescribing controlled substances for chronic pain and mental health, including bipolar disorder, post-traumatic stress disorder and generalized anxiety.

43. Respondent documented no progress notes for Patient P prior to November 2011, despite prior prescribing of controlled substances and intake records dated in 2009. There is no documented diagnosis prior to the prescribing of controlled substances to Patient P.

44. The prescribing to Patient P included diazepam 10 mg (Schedule IV), lorazepam 1 mg (Schedule IV), methylphenidate 20 mg (Schedule II), oxycodone 30 mg (Schedule II), oxycodone-acetaminophen 10-325 (Schedule II), oxymorphone 30 mg (Schedule II), and Androgel (Schedule III).

Patient G

45. Respondent began treating Patient G in at least 2003, and treatment continued through at least 2017. Respondent's treatment of Patient G included prescribing controlled substances for chronic pain and controlled substances typically prescribed for Attention Deficit Disorder ("ADD") or Attention Deficit Hyperactivity Disorder ("ADHD"), but there is no documented diagnosis of ADD or ADHD in the record. There are no documented diagnoses at all prior to the prescribing of controlled drugs to Patient G.

46. Sporadic prescription records in Patient G's file document the prescribing of controlled substanes, including oxycodone-acetaminophen (Schedule II) and alprazolam (Schedule IV) between 2003 and 2005 and 2009 and 2011.

47. PMP records, beginning in 2011, document that Respondent prescribed oxycodone-acetaminophen 5-325 (Schedule II) and methylphenidate 10 mg and 20 mg (Schedule II) to Patient G.

48. Other than copies of certain prescriptions, Respondent maintained no records on Patient G between 2003 and 2009 and February 2012 and 2017 despite prescribing of controlled drugs during these times.

Patient J

49. Respondent began treating Patient J in at least 2006, and treatment continued through at least 2013. Respondent's treatment of Patient J included prescribing controlled

substances for chronic pain and mental health including adjustment disorder, depression and anxiety.

50. Prescription records in Patient J's file document that Respondent prescribed oxycodone-acetaminophen (Schedule II), clonazapem (Schedule IV), oxycodone (Schedule II) and methylphenidate (Schedule II) between March 2006 and November 2007, but there are no progress notes in the file dated before December 2008. There is no documented diagnosis prior to the prescribing of controlled substances to Patient J.

51. PMP records document that Respondent prescribed of Oxycontin 40 mg (Schedule II), oxycodone 30 mg (Schedule II) methylphenidate 20 mg (Schedule II), and pregabalin 75 mg and 150 mg (Schedule V) to Patient J between September 2011 and April 2013.

Patient J2

52. Respondent began treating Patient J2 in at least 2008, and treatment continued through at least 2014. Respondent's treatment of Patient J2 included prescribing controlled substances for chronic pain and mental health including anxiety, depression and adjustment disorder.

53. Prescription records in Patient J2's file document the prescribing of controlled substances, including Percocet (Schedule II), diazepam (Schedule IV), and Xanax (Schedule IV) beginning in October 2008. The psychiatric evaluation for Patient J2 for October 2008 is blank and there is no documented diagnosis prior to the prescribing of controlled substances to Patient J2.

54. PMP records document Respondent's prescribing of oxycodone 15 mg (Schedule II), alprazolam 1 and 2 mg (Schedule IV), hydrocodone-acetaminophen 10-325 and 7.5-325 (Schedule II) to Patient J2 between September 2011 and December 2014.

55. In May 2011, after prescribing controlled substances to Patient J2 for several years, Respondent requested records from another provider. The records document that Patient J2 was receiving Percocet from Dr. Damon Cary beginning in October 2008 and continuing until August 2010. This prescribing overlapped with Percocet prescribing by Respondent. After receiving this information in 2011, Respondent did not discuss it with the patient and continued to prescribe controlled drugs as usual.

56. Respondent prescribed controlled substances to Patients U, M, T, D, P, G, J, and J2, ("Patients") and failed to comply with the Board's Regulations on the Use of Controlled Substances for the Treatment of Pain. He failed to:

a. Obtain prior treatment records or otherwise communicate or coordinate with prior providers to obtain a comprehensive medical history;

b. Adequately evaluate the patients or document evaluation of the patients to include medical histories, physical examinations, nature and intensity of pain, current and past treatments for pain, underlying coexisting diseases or conditions, effect of pain on physical and psychological function, history of substance abuse, and the presence of one or more recognized medical indications for the use of a controlled substance;

c. Utilize a written treatment plan addressing goals and objectives of treatment, plans for further diagnostic evaluations or other treatments, or the necessity of further treatment modalities depending on the etiology of the pain and the extent to which the pain is associated with physical or psychosocial impairment;

d. Adjust drug therapies to meet the patients' individual needs or document an

explanation for increases, decreases or other changes in drug therapies;

e. Discuss or document that he had discussed risks and benefits of the use of controlled substances with the patients;

f. Utilize or enforce treatment agreements;

g. Appropriately identify or respond to red flags for medication abuse;

h. Refer patients for additional evaluation and treatment in order to achieve treatment objectives or follow up on referrals;

i. Periodically review the course of pain treatment and any new information about the etiology of the pain and patient's state of health to include evaluation of the appropriateness of continued use of controlled substances that did not lead to patient improvement, including, but not limited to, satisfactory response to treatment indicated by decreased pain, increased level of function, or improved quality of life; and

j. Keep accurate, complete and accessible patient records.

Patient D2

57. Respondent treated Patient D2 for anxiety and pain management until at least October of 2015. Respondent's treatment of Patient D2 included prescribing controlled substances for chronic pain and mental health.

58. Respondent routinely prescribed methylphenidate (Schedule II) to Patient D2. Patient D2 did not typically use all of the methylphenidate and reported to Respondent that he could not sleep on the drug and had increased anxiety. Respondent continued to prescribe methylphenidate to Patient D2 and had Patient D2 provide him with the unused pills.

59. Patient D2 routinely provided Respondent with most or all of his methylphenidate

prescription. Respondent occasionally paid Patient D2 for the pills.

60. On several occasions, Patient D2 observed Respondent ingest the methylphenidate pills.

61. During an appointment in 2014, Patient D2 was in the office when several law enforcement officers arrived at Respondent's office. Respondent handed Patient D2 a 9 mm handgun and switchblade from his desk drawer and Patient D2 took the weapons home. Patient D2 returned the weapons to Respondent approximately one month later.

Illegal Handling of Controlled Drugs

62. On September 21, 2017, investigators from the DPR reported to Respondent's practice to obtain subpoenaed records.

63. In plain view in the reception area, was a bottle of Tizanidine HCL 4mg, a prescription medication belonging to a patient. The drug was issued on November 10, 2014 and expired on November 10, 2015.

64. Investigators discovered additional medications in an unsecured cabinet, prescribed to various individuals, both male and female. The medications included:

a. Multiple bottles of expired antidepressants, antipsychotics and other samples;

b. An expired bottle of hyrdrocodone/chlorpheniramine (Tussionnex) (Schedule II) issued to a female with an expiration date of December 14, 2011;

c. Two expired bottles of Temazepam 15 mg (Schedule IV) issued to a female on September 14, 2016;

d. A bottle of Gabapentin 300 MG issued to a female on June 16, 2016;

e. Testosterone CYP 200 mg (Schedule III) issued to a male patient of Respondent on May 23, 2013;

f. A bottle of Ketorolac Tromethamine 60 mg, 2 ml;

g. A bottle of Citalopram prescribed to a patient of Respondent;

h. A bottle of Quetiapine 25 mg (Seroquel) prescribed to a patient of Respondent;

i. Cymbalta prescribed to a female; and

j. Depo-Medrol (methylprednisolone) 40 mg 5 ml, prescribed to Respondent's office and filled on March 4, 2008.

65. Respondent provided patients with medication from the various bottles in his office, even when the medication was prescribed to individual other than the recipient.

66. In the kitchen of the practice, DPR investigators also observed medical devices mixed in among over-the-counter medications, alcohol, insecticide, rodenticide and hazardous waste. They observed three large sharps containers, two over flowing with syringes, and open plastic bags with used swabs and gauze. Investigator also found expired urine test kits and lancets on shelves and many ripped open sterile swab and gauze pads mixed throughout sealed packs.

67. DPR investigators discovered two handguns in a safe in Respondent's office, not registered to Respondent. Respondent admitted they belonged to patients and claimed they came from patients concerned with harming themselves. Respondent, however, has been known to barter guns for medical services.

68. Respondent routinely barters with patients in exchange for medical services and has patients do work around his practice, including yard work, interior maintenance, and remodeling. Respondent barters for services with patients to whom prescribes controlled drugs.

69. Respondent violated 24 *Del. C.* § 1731(b)(1) as he used a false, fraudulent, or forged statement or document or fraudulent, deceitful, dishonest, or unethical practice in connection with a certification, registration, or licensing requirement of Chapter 17 of Title 24, or in connection with the practice of medicine.

70. Respondent violated 24 *Del. C.* § 1731(b)(2) as he engaged in conduct that would constitute a crime substantially related to the practice of medicine.

71. Respondent violated 24 *Del. C.* § 1731(b)(3) and:

a. Regulation 8.1.2 as he exploited the doctor/patient privilege for personal gain;

b. Regulation 8.1.12 as he failed to comply with the Board's regulations governing the use of controlled substances for the treatment of pain;

c. Regulation 8.1.13 as he failed to adequately maintain and properly document patient records; and

d. Regulation 8.1.16 as he engaged in conduct tending to bring discredit upon the profession.

72. Respondent violated 24 *Del. C.* 1731(b)(6) as he used, distributed or issued a prescription for a dangerous or narcotic drug, other than for therapeutic or diagnostic purposes.

73. Respondent violated 24 *Del. C.* § 1731(b)(11) in that he demonstrated misconduct, including but not limited to incompetence, or gross negligence or pattern of negligence in the practice of medicine or other profession or occupation regulated under Chapter 17 of Title 24.

74. Respondent violated 24 *Del. C.* § 1731(b)(17) as he violated a provision of Chapter 17 or an order or regulation of the Board related to medical procedures, the violation of which more probably than not will harm or injure the public or an individual.

75. Respondent's conduct as documented throughout this Amended Complaint presents a clear and immediate danger to the public health. The State, through undersigned counsel, requests emergency action to temporarily suspend Respondent's Delaware medical license pending a final hearing on the Amended Complaint pursuant to 24 *Del. C.* § 1738(a).

WHEREFORE, pursuant to 29 *Del. C.* § 8735 and 24 *Del. C.* Chapter 17, the State of Delaware respectfully requests that the Board:

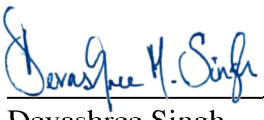
a. Enter an Order pursuant to 24 *Del. C.* § 1738(a) for the temporary suspension of Respondent's license due to the clear and immediate danger he poses to the public health;

b. Serve Respondent with a copy of the Amended Complaint and Motion for Temporary Suspension pursuant to 24 *Del. C.* § 1738(a);

c. Schedule a hearing on the Amended Complaint after suspending Respondent's license;

d. Find Respondent guilty of violating 24 *Del. C.* § 1731 as alleged herein; and

e. Permanently revoke Respondent's license to practice medicine or take such other action as deemed appropriate by the Board.



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Dated: 3.16.2018

/s/ Stacey X. Stewart
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Dated: March 15, 2018